Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/29/03.

I. DISPUTE

Whether there should be reimbursement for date of service 9/19/03, HCPCS code A4647.

II. RATIONALE

The service in dispute was denied as, "F-284-Reduced according to fee guideline; no allowance was recommended as this procedure indicates a status 'B'."

The Requestor states, on the Table of Disputed Services, "The following claim has been resubmitted and denied as not being reasonable. Nonionic contrast material for radiological procedures shall be billed using one of these codes, A4644 – A4647. Nonionic contrast was used in this procedure."

The Carriers states, on their Reevaluation dated 1/20/04, "Provider has billed and was reimbursed for Omnipaque (nonionic contrast). Documentation does not support a second billing of Omnipaque."

Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section." To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: Rule 134.202 (c) (1) states, "For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology. The conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by Centers for Medicare and Medicaid Services multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used." Section (c)(2)(A) states, "For Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E, J, K, and L: 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

Per the Medicare Carrier Manual, 15022 Payment Conditions for Radiology Services (6) states, "The RVUs for MRI procedures that specify 'with contrast' include payment. Do not make separate payment under code A4647." Therefore, reimbursement is not recommended.

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 31st day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc